

Healthy Aging Program: Huron Shores Family Health Team

Fall 2025



Healthcare Excellence Canada would like to formally acknowledge Huron Shores Family Health Team's generosity in sharing their skills, knowledge, expertise and experiences to inform this promising practice.

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Enabling Aging in Place collaborative

The Enabling Aging in Place collaborative brought together health and social service organizations from across the healthcare continuum to implement promising practices that can delay people's entry into long-term care. The collaborative aimed to improve safety, health and quality-of-life outcomes, while also reducing emergency department visits, lessening demands on care partners and making better use of health and social care resources.

Teams from communities across the country participated in the Enabling Aging in Place collaborative.



Healthy Aging Program

Huron Shores Family Health Team's (HSFHT) Healthy Aging Program aims to improve the lives of older adults by promoting well-being and helping them stay independent and active in their community. The program focuses on preventing and managing age-related health challenges for individuals aged 65 and older.

HSFHT developed the Healthy Aging Program intending it as an early frailty identification and management program. Individuals living with frailty are at higher risk of fall-related injuries, which can lead to increased emergency department visits, extended hospitalization and entry to long-term care. Thirty percent of residents in East Algoma, a rural area in Northeastern Ontario, are over the age of 65, which is higher than the provincial average. By identifying and supporting individuals living with frailty, HSFHT aims to reduce demand on the local healthcare system.

In the early phases of the program, the team engaged local community members in focus groups. These discussions provided valuable insights, including a recommendation for public education on healthy aging in the community.

Engaging with the community from the beginning changed HSFHT's approach. The team expanded from early frailty screening to a more comprehensive healthy aging program that better meets the target population's needs.

HSFHT's Healthy Aging Program now comprises annual health screening, a Healthy Aging Listen and Learn series, public education events including health fairs, fall prevention programs, referrals and health resources. This multi-component approach supports HSFHT in identifying frailty earlier and providing community members with strategies to positively influence their well-being.

Key Features

Objectives

The objectives of the Healthy Aging Program are to:

- increase health literacy and navigation support for older adults
- increase opportunities for older adults to access frailty prevention and management-based screening
- increase awareness of and participation in community programs and health services
- increase opportunities for patients without a primary care provider (PCP) to access healthcare services
- prevent and delay negative impacts associated with frailty and falls (e.g. hospitalization and entry to long-term care.)

Population served

The Healthy Aging Program supports people living in the community in the HSFHT catchment area of East Algoma. HSFHT has four sites, located in Blind River, Bruce Mines, Richards Landing and Thessalon. The program is offered at each site, at no cost, and is open to all individuals within the catchment area, with or without a current PCP.

The public education events are geared towards middle-aged and older adults to increase knowledge and address negative stereotypes and perceptions of aging.

The screening component is currently for those aged 65 years and older. However, to further address healthy aging, the team is exploring lowering the screening's minimum age, allowing for even earlier identification of potential problems.

Program team

Implementation of the program is supported by an Algoma Ontario Health Team consultant, the HSFHT Executive Director and their interdisciplinary team comprising:

- **Physiotherapist** – project lead, trains staff, develops and delivers public education events and offers osteoporosis group classes
- **System navigator** – develops and maintains information handouts and asset map of community supports, develops public education events and manages data

- **Nursing lead (RN)** – provides front-line insight to the project, trains staff and develops public education events
- **Registered nurses (RN)** – conduct level 2 screening and education
- **Registered practical nurses** – conduct level 1 screening and education and assist with fall prevention programs
- **Physiotherapy assistant** – delivers fall prevention programs and group exercise classes
- **Administrative support** – supports the program's administrative needs

Healthy Aging Program

HSFHT has implemented a multi-component approach to help older adults promote their well-being and stay independent and active in their communities. The program includes level 1 annual frailty screening for individuals aged 65+, level 2 multifactorial frailty screening for those identified as living with frailty, and healthy aging awareness and education events throughout their communities.

Healthy Aging Screening

The Healthy Aging Screening tool was developed specifically for this program, based on a modified version of the C5-75 tool¹, the Clinical Frailty Scale² and a validated falls risk self-assessment tool. These tools are embedded in HSFHT's electronic medical

¹ Lee L, Jones A et al. The C5-75 Program: Meeting the Need for Efficient, Pragmatic Frailty Screening and Management in Primary Care. Can

J Aging. 2021 Jun;40(2):193-205. doi: 10.1017/S0714980820000161.

² Mendiratta P, Schoo C, Latif R. Clinical Frailty Scale. [Updated 2023 Apr 23].

record. The screening guides providers to use evidence-based questions and assessments to identify frailty and falls risk in patients.

This annual screening approach provides an opportunity for older adults to be identified before a significant event or significant change to their functional ability occurs. It also offers older adults an opportunity to discuss concerns that are less likely to be covered in a general primary care appointment.

The screening tool has built-in prompts that recommend specific referrals to services and written resources that can be shared with the older adult. The recommended resources include published documents as well as materials created by HSFHT to meet the needs of the program and geographic location.

Considerable resources and effort were allocated to supporting nursing staff in implementing the screening process. This includes the development of detailed training materials, which are also beneficial for managing staff turnover and onboarding.

People can either be referred to Healthy Aging Screening by their PCP or allied healthcare professionals, or they can self-refer.

Level 1 screening

Level 1 screening is completed annually for individuals aged 65 and older. Older adults are asked questions about what matters most to them as they age, their level of physical activity, falls and more. Their responses may prompt referrals to other HSFHT programs, and older adults are also provided with written resources based on their screening.

If the level 1 screening does not prompt a referral to the level 2 screening, the provider will complete a falls risk tool with the older

adult. Based on the results, the older adult may be referred to Level 2 screening.

Level 2 screening

Individuals identified as living with frailty during level 1 screening are then booked for level 2. This screening examines multiple domains (e.g. physical, psychological/cognitive, social) to identify factors contributing to an individual's frailty. Based on this multifactorial screening, the RN takes a holistic approach to recommendations for supporting the older adult in their healthy aging journey. Where applicable, caregiver burden is also assessed using the Zarit Caregiver Burden Interview.³

Once the assessment has been completed, a care plan – including appropriate referrals or interventions – will be developed to support the older adult in achieving their goals of care. For individuals experiencing mild to moderate frailty, referrals may include to various HSFHT or other community-based programs and services such as dietitians, physiotherapy, fall prevention programs, chronic disease management programs and/or seniors mental health services. Individuals who are moderately to severely frail may also receive a referral to specialized geriatric services for further assessment and support.

While many of these referrals can be generated directly by the RN, some require a visit with the patient's PCP. For those who do not have a PCP, HSFHT's nurse practitioner will see them and initiate the referral as well as provide follow-up. Patients are also offered written resources with information on relevant topics, such as adjusting their mobility aid, cognitive health, hearing loss and more.

³ American Psychological Association. Zarit Burden Interview. 2020.

<https://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/zarit>

Screening follow-up visit

Once an older adult completes Healthy Aging Screening, they will be scheduled for a follow-up visit within two to three months. The purpose of this visit is to follow up on any recommendations, ensure referrals have not been missed, address new concerns and respond to questions. Individuals are also scheduled for their annual screening for the following year.



Public education on healthy aging

As highlighted in the focus groups, general education about healthy aging was a priority for the communities as well as healthcare providers. To respond to this, HSFHT offers various public education events to all adults, at no cost, to provide information on healthy aging. These sessions feature special guests, who present on topics such as modifiable risk factors, what frailty means and local services available. Each session also provides tailored written resources on the topics – a strong request from focus groups participants.

HSFHT organizes annual Healthy Aging Fairs in two of its communities and participates in one organized by another community. These fairs are designed to help community members know what is available in their community, as well as showcase what can be done to help prevent problems.

Through the Healthy Aging program, HSFHT holds interactive educational sessions, including sessions on fall prevention and osteoporosis management, as well as sessions demonstrating the use of assistive devices such as walking poles.

Implementation context

HSFHT is in East Algoma, a large rural area where there is limited access to home care and community support services, as well as public transportation. This contrasts with the communities where the C5-75 screening tool was originally developed and where services for referral were more readily available.

To address some of these barriers, HSFHT worked extensively to create asset maps of the communities it serves. This ensures that the team has accurate information on the health and community services available so it can provide older adults with local support options. The team also considers an individual's location and access to transportation in determining which referrals to provide. This helps ensure individuals can access the services to which they are referred. HSFHT is also creative in the interventions it provides, such as:

- offering vouchers for pelvic floor physiotherapy when incontinence is an issue (this service is offered only in urban areas and is not publicly funded)
- operating a small assistive devices program available at no cost for those who require them, including long-handled reachers, sock aids and various walking poles
- offering various groups at its different sites depending on each community's needs

Outcomes⁴

Increased knowledge of healthy aging strategies

Ninety-nine percent of public education session participants surveyed agreed that the sessions improved their knowledge of healthy aging.

“Healthy Aging education presentations are giving older adults a chance to learn from various healthcare professionals and ask questions, which makes their learning experience individualized and meaningful.”

– HSFHT program team member

Improved access to services for unattached patients

The Healthy Aging Program has increased access to healthcare services in the region for all older adults, including individuals who do not have a PCP.

Twenty-nine percent of the Healthy Aging appointments and 46 percent of the referrals have been for unattached patients. Prior to the Healthy Aging Program, options were limited for individuals who were unattached to primary care. Although they could visit a hospital emergency department for acute issues, they had no routine preventative or follow-up care.

The Healthy Aging Program provides preventative care as well as navigation support to other services that can support them to age well.

“Being that I do not have a family doctor, it is nice to get services that will help with my diabetes, in preventative medicine.”

– Healthy Aging Program participant

Delayed entry to long-term care

One hundred percent of clients surveyed agreed that the Healthy Aging Screening process had enabled them to age in place longer.

Through education and individualized healthcare interventions, Healthy Aging Screening participants have gained insight into the risk factors that could lead to early entry into long-term care and how to mitigate those risks. This knowledge is helping them – and their loved ones – delay entry into long-term care.

⁴ The outcome and impact information shared reflects information available at the time of writing this promising practice. HEC would like to acknowledge that evaluation activities are an ongoing process for many promising practices and

the type of data collected is influenced by program goals, the length of time the program has been implemented and the level of resources available to support evaluation.

“Very helpful in explaining all we as seniors need to hear & do. It is something I need to be doing in order to stay healthy & have quality of life in my own home!”

– Healthy Aging Program participant

Funding

The Healthy Aging Program is supported by HSFHT. The program is now a part of the HSFHT’s Annual Operating Plan with interdisciplinary team members supporting the program at all four sites. It has also been supported by the Algoma Ontario Health Team through multiple one-time funding opportunities, including base funding for a permanent part-time physiotherapy assistant. Local municipal and health organizations have provided in-kind contributions.

Asset-Based Community Development Approach

Asset-Based Community Development (ABCD) is a strengths-based approach to solving challenges in communities that focuses on and develops the strengths of local assets (e.g. people, physical assets) that are key to ensuring a sustainable community.

Through learning about the ABCD approach, the HSFHT began program development by bringing together local older adults and care partners in focus groups to co-develop goals and the approach to the program. These sessions included discussions of the four modes of social change (To/For/With/By).

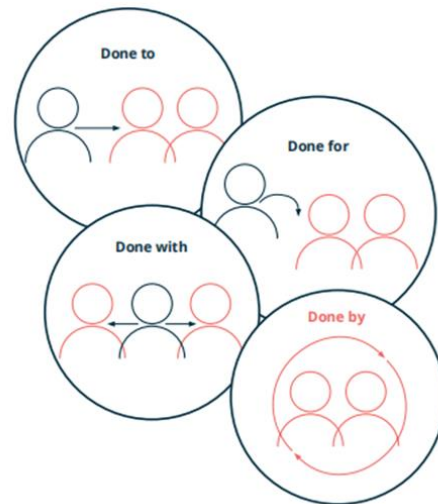


Figure 1: The Helper’s Crossroads⁵

⁵ Russell C. www.nurtureddevelopment.org

Contact: cormac@nurtureddevelopment.org.

The “To” and “For” modes depicted in figure 1 are the traditional approach used in healthcare, but the team used this opportunity to explore community development activities that are done “With” and “By” the community. These focus groups and this framing provided insights into planning and the best approach to an effective healthy aging program in the communities.

The focus groups revealed early on that stigma associated with aging and frailty may decrease the likelihood that some individuals will engage with the program and supports provided. Participants provided ideas and approaches to address this and work to better engage the population in the program.

It was critical for HSFHT to include older adults and care partners in program planning from the beginning to develop an effective program from the participants’ perspective. For example, one of the insights that came from the focus groups was that the community wished to have a better understanding of service availability across the area HSFHT serves, not just services directly provided by HSFHT. Community members also suggested that by having prior access to education on healthy aging, individuals who participated in the screening would be more open to the recommended interventions, increasing their effectiveness. This approach allowed HSFHT to design a screening and management process that reflects the priorities of older adults and care partners, increasing their willingness to engage with the program.

The HSFHT has also developed a comprehensive community asset map to improve older adults’ access to local services. Created in collaboration with community members and organizations, the map helps address gaps in awareness of available supports. What began as a tool for providers quickly grew in demand as community members requested it to better understand the

range of local opportunities. Given the rural nature of the region and its transportation challenges, the map also helps ensure that referrals connect older adults to services they can realistically access.

Partnerships

HSFHT has strong connections and partnerships to draw upon in supporting this program.

Partnerships in the development and implementation of the program include:

- **Algoma Ontario Health Team** – Provided implementation support as well as connections with other health and social service agencies to promote integrated care for older adults.
- **North Shore Health Network** – Members participated in the working group, helped plan some public education events and, when an individual was identified as living with moderate to severe frailty, the individual could be referred to NSHN’s geriatrician for further assessment and management.
- **Algoma Geriatric Clinic (Sault Area Hospital)** – A geriatric assessor participated in the working group, helped plan some public education events and, when an individual was identified as living with moderate to severe frailty, the individual could be referred to AGC for further assessment and management.
- **North East Specialized Geriatric Centre** – Provided access to clinical services, education and resources in addition to conducting research and evaluations.

Connections with and between health and social service providers along the North Shore are strong, and HSFHT has leveraged these relationships to ensure patients are best supported with the services that are available.

In addition to health system partners, HSFHT has built strong partnerships with local municipalities and community organizations. The following partners have provided resources for the HSFHT program, including space and advertising for programs:

- **Dr. Trefry Memorial Centre** – The Senior Services program provides community services for older adults to remain in their own home and hosts various social events.
- **Town of Blind River** – Hosts opportunities for older adults to be referred, including the 50+ Club, North of 50 Club and Blind River Public Library (which hosts numerous activities).
- **Town of Thessalon** – Hosts opportunities for older adults to be referred; HSFHT participated in their Healthy Aging Wellness Fair.

This promising practice was co-produced with the Huron Shores Family Health Team. Information was compiled in fall 2025. In keeping with the changing and evolving nature of care, the information may change in the future. We encourage you to reach out to this team for any further information that may be helpful as you work to improve care for those you serve.

How can I learn more?

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